



DEPARTMENT OF DEFENSE

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Office of the Secretary

32 CFR Part 199

DOD-2011-HA-0058

RIN 0720-AB51

TRICARE; Constructive Eligibility for TRICARE Benefits of Certain Persons Otherwise Ineligible Under Retroactive Determination of Entitlement to Medicare Part A Hospital Insurance Benefits

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Final rule.

SUMMARY: The Department is publishing this final rule to implement section 706 of the National Defense Authorization Act (NDAA) for Fiscal Year 2010, Public Law 111-84. Specifically, section 706 exempts TRICARE beneficiaries under the age of 65 who become disabled from the requirement to enroll in Medicare Part B for the retroactive months of entitlement to Medicare Part A in order to maintain TRICARE coverage. This statutory amendment and final rule only impact eligibility for the period in which the beneficiary's disability determination is pending before the Social Security Administration. Eligible beneficiaries are still required to enroll in Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A. This final rule also amends the eligibility section of the TRICARE regulation to more clearly address reinstatement of TRICARE eligibility following a gap in coverage due to lack of enrollment in Medicare Part B.

EFFECTIVE DATE: This final rule is effective [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Ms. Anne Breslin, TRICARE Operations Branch, TRICARE Management Activity (TMA), 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041, telephone (703) 681-0039.

SUPPLEMENTARY INFORMATION:

I. Background

Prior to the enactment of section 706 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84), 10 U.S.C. 1086(d) provided that a person who would otherwise receive benefits under section 1086 who is entitled to Medicare Part A hospital insurance is not eligible for TRICARE unless the individual is enrolled in Medicare Part B. When a TRICARE beneficiary becomes eligible for Medicare, Medicare becomes the primary payer and TRICARE is the secondary payer. Retroactive Medicare eligibility determinations therefore caused DoD and Medicare to reprocess claims. Section 706 of the Fiscal Year 2010 National Defense Authorization Act amended 10 U.S.C. 1086(d) to exempt TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination from the requirement to enroll in Medicare Part B for the retroactive months of entitlement to Medicare Part A in order to maintain TRICARE coverage. This statutory amendment became effective upon enactment of the Fiscal Year 2010 National Defense Authorization Act on October 28, 2009. Prior to this amendment, beneficiaries who did not purchase Medicare Part B to cover the retroactive period lost their TRICARE eligibility during that period of time. As a result, beneficiaries and providers were then subject to TRICARE recoupment action for care provided during the period of retroactive disability. Pursuant to this

amendment, TRICARE remains first payer for any claims filed during the retroactive months and disabled TRICARE beneficiaries are relieved of the financial burden of making retroactive payments to avoid a gap in coverage. This final rule amends the Code of Federal Regulations to conform to current statutory authority regarding TRICARE eligibility.

Additionally, due to an earlier administrative omission, this final rule also amends 32 CFR 199.3 to more clearly address reinstatement of TRICARE eligibility following a gap in coverage due to lack of enrollment in Part B. While most TRICARE beneficiaries who become eligible for Medicare Part A maintain TRICARE coverage through prompt acceptance of Part B coverage, there are a number of beneficiaries that for one reason or another decline Part B and lose their TRICARE eligibility. For those individuals, they can have that eligibility reinstated at a later date if they re-enroll in Part B. This final rule amends the section on reinstatement of TRICARE eligibility to include beneficiaries who elect to enroll in Medicare Part B following a gap in TRICARE coverage.

II. Public Comments

We provided a 60-day public comment period following publication of the Proposed Rule in the **Federal Register** (76 FR 58204-58206) on September 20, 2011. We received no public comments.

III. Regulatory Procedures

Executive Order 12866, ‘‘Regulatory Planning and Review’’; Executive Order 13563, ‘‘Improving Regulation and Regulatory Review’’; and Public Law 96–354, ‘‘Regulatory Flexibility Act’’ (5 U.S.C. § 601)

Executive Orders 12866 and 13563 require that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one that

would result in an annual effect of \$100 million or more on the national economy or which would have other substantial impacts. The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This rule is not an economically significant regulatory action and will not have a significant impact on a substantial number of small entities for purposes of the RFA, thus this final rule is not subject to any of these requirements.

Paperwork Reduction Act of 1995 (44 U.S.C. § 3501–3511)

This rule will not impose additional information collection requirements on the public. OMB previously cleared the collection requirements under OMB Control Number 0704–0364.

Executive Order 13132, ‘Federalism’

We have examined the impact(s) of the rule under Executive Order 13132, and it does not have policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, therefore, consultation with State and local officials is not required.

Sec. 202, Public Law 104–4, ‘Unfunded Mandates Reform Act’

This rule does not contain unfunded mandates. It does not contain a Federal mandate that may result in the expenditure by State, local, and tribal governments, in aggregate, or by the private sector, of \$100 million or more in any one year.

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR part 199 is amended as follows:

PART 199—[AMENDED]

1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55

2. Section 199.3 is amended by:

- a. Adding paragraph (f)(2)(iii);
- b. Revising paragraph (f)(3)(ix)(C); and
- c. Adding paragraph (g)(3) to read as follows:

§ 199.3 Eligibility

* * * * *

(f) * * *

(2) * * *

(iii) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii) and (f)(3)(ix) of this section.

(3) * * *

(ix) * * *

(C) The individual is enrolled in Part B of Medicare except that in the case of a retroactive determination of entitlement to Medicare Part A hospital insurance benefits for a person under 65 years of age there is no requirement to enroll in Medicare Part B from the Medicare Part A entitlement date until the issuance of such retroactive determination; and

* * * * *

(g) * * *

(3) Enrollment in Medicare Part B. For individuals whose CHAMPUS eligibility has terminated pursuant to paragraph (f)(2)(iii) or (f)(3)(vi) of this section due to beneficiary action to decline Part B of Medicare, CHAMPUS eligibility resumes, effective on the date Medicare Part B coverage begins, if the person subsequently enrolls in Medicare Part B and the person is otherwise still eligible.

3. Section 199.8 is amended by:

- a. Revising paragraph (d)(1)(i);
- b. Redesignating paragraphs (d)(1)(vi), (d)(1)(vii) and (d)(1)(viii) as (d)(1)(vii), (d)(1)(viii), and (d)(1)(ix) respectively; and
- c. Adding new paragraph (d)(1)(vi) to read as follows.

§ 199.8 Double coverage.

* * * * *

(d) * * *

(1) * * *

(i) General rule. In any case in which a beneficiary is eligible for both Medicare and CHAMPUS received medical or dental care for which payment may be made under Medicare and CHAMPUS, Medicare is always the primary payer except in the case of retroactive determinations of disability as provided in paragraph (d)(1)(v) of this section. For dependents of active duty members, payment will be determined in accordance to paragraph (c) of this section. For all other beneficiaries eligible for Medicare, the amount payable under CHAMPUS shall be the amount of actual out-of-pocket costs incurred by the beneficiary for that care over the sum of the amount paid for that care under Medicare and the total of all amounts paid or payable by third party payers other than Medicare.

* * * * *

(vi) Retroactive determinations of disability. In circumstances involving determinations of retroactive Medicare Part A entitlement for persons under 65 years of age, Medicare becomes the primary payer effective as of the date of issuance of the retroactive determination by the Social Security Administration. For care and services rendered prior to issuance of the retroactive determination, the CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(B) of this section notwithstanding the beneficiary's retroactive entitlement for Medicare Part A during that period.

* * * * *

4. Section 199.11 is amended by revising paragraph (f)(3) to read as follows:

§ 199.11 Overpayments recovery.

* * * * *

(f) * * *

(3) Claims arising from erroneous TRICARE payments in situations where the beneficiary has entitlement to an insurance, medical service, health and medical plan, including any plan offered by a third party payer as defined in 10 U.S.C. 1095(h)(1) or other government program, except in the case of a plan administered under Title XIX of the Social Security Act (42 U.S.C. 1396, et seq.) through employment, by law, through membership in an organization, or as a student, or through the purchase of a private insurance or health plan, shall be recouped following the procedures in paragraph (f) of this section. If the other plan has not made payment to the beneficiary or provider, the contractor shall first attempt to recover the overpayment from the other plan through the contractor's coordination of benefits procedures. If the overpayment cannot be recovered from the other plan, or if the other plan has made payment, the overpayment

will be recovered from the party that received the erroneous payment from TRICARE. Nothing in this section shall be construed to require recoupment from any sponsor, beneficiary, provider, supplier and/or the Medicare Program under Title XVIII of the Social Security Act in the event of a retroactive determination of entitlement to SSDI and Medicare Part A coverage made by the Social Security Administration as discussed in § 199.8(d) of this part.

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DATED: June 20, 2012.

Patricia L. Toppings,
OSD Federal Register Liaison Officer
Department of Defense

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